

Case Number:	CM14-0096204		
Date Assigned:	09/15/2014	Date of Injury:	03/11/2011
Decision Date:	10/17/2014	UR Denial Date:	05/28/2014
Priority:	Standard	Application Received:	06/24/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Orthopedic Surgery, has a subspecialty in Spine Surgery and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

According to the records made available for review, this is a 53-year-old female with a 3/11/11 date of injury, and status post C4-C7 anterior cervical decompression and fusion on 8/3/12. At the time (10/8/13) of request for authorization for C4-5 removal of cervical spine hardware with inspection of the fusion mass and possible regrafting, C4-5 anterior cervical discectomy and fusion with instrumentation, iliac crest aspiration/harvesting, possible junctional levels, there is documentation of subjective (continued pain in the cervical spine) and objective (limitation of cervical spine on terminal ranges of motion) findings, imaging findings (not specified), current diagnoses (status post C4-C7 hybrid cervical reconstruction), and treatment to date (anterior cervical decompression and fusion, and medications). In addition, medical report identifies minimal cervical symptomatology, if any; and that the intervertebral implant that was placed at the level of C4-5 has stabilized. There is no documentation of a diagnostic hardware injection, broken hardware or persistent pain; subjective (pain, numbness, or tingling) and objective (sensory changes, motor changes, or reflex changes) radicular findings in the requested nerve root distribution, imaging findings (nerve root compression OR moderate or greater central canal stenosis, lateral recess stenosis, or neural foraminal stenosis) at the requested level, and failure of additional conservative treatment (activity modification and physical modalities).

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

C4-5 removal of cervical spine hardware with inspection of the fusion mass and possible regrafting, C4-5 anterior cervical disectomy and fusion with instrumentation, iliac crest aspiration/harvesting, possible junctional levels: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disabilities guidelines

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 180. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter; Neck and Upper Back Chapter, Hardware injection (block), Hardware implant removal (fixation); Discectomy/laminectomy/laminoplasty; Fusion, anterior cervical

Decision rationale: Regarding hardware removal, MTUS does not address this issue. ODG identifies documentation of a diagnostic hardware injection to determine if continued pain is caused by the hardware, as criteria necessary to support the medical necessity of hardware removal. In addition, ODG does not recommend the routine removal of hardware implanted for fixation, except in the case of broken hardware or persistent pain, after ruling out other causes of pain such as infection and nonunion. Regarding anterior cervical discectomy and fusion, MTUS reference to ACOEM guidelines identifies documentation of persistent, severe, and disabling shoulder or arm symptoms; activity limitation for more than one month or with extreme progression of symptoms; clear clinical, imaging, and electrophysiology evidence, consistently indicating the same lesion that has been shown to benefit from surgical repair both in the short and the long term; and unresolved radicular symptoms after receiving conservative treatment, as criteria necessary to support the medical necessity of cervical decompression. ODG identifies documentation of subjective (pain, numbness, or tingling in a correlating nerve root distribution) and objective (sensory changes, motor changes, or reflex changes (if reflex relevant to the associated level) in a correlating nerve root distribution) radicular findings in each of the requested nerve root distributions, imaging (MRI, CT, myelography, or CT myelography & x-ray) findings (nerve root compression OR moderate or greater central canal stenosis, lateral recess stenosis, or neural foraminal stenosis) at each of the requested levels, and failure of conservative treatment (activity modification, medications, and physical modalities), as criteria necessary to support the medical necessity of cervical decompression. In addition, ODG identifies anterior cervical fusion is recommended as an option in combination with anterior cervical discectomy for approved indications. Within the medical information available for review, there is documentation of diagnoses of status post C4-C7 hybrid cervical reconstruction. However, despite documentation of subjective findings (continued pain in the cervical spine), and given documentation identifying minimal cervical symptomatology, if any; and that the intervertebral implant that was placed at the level of C4-5 has stabilized, there is no documentation of broken hardware or persistent pain. In addition, there is no documentation of a diagnostic hardware injection. Furthermore, despite documentation of subjective (continued pain in the cervical spine) and objective (limitation of cervical spine on terminal ranges of motion) findings, there is no documentation of subjective (pain, numbness, or tingling) and objective (sensory changes, motor changes, or reflex changes) radicular findings in the requested nerve root distribution. Moreover, there is no documentation of imaging (MRI, CT, myelography, or CT myelography & x-ray) findings (nerve root compression OR moderate or greater central canal stenosis, lateral recess stenosis, or neural foraminal stenosis) at each of the requested levels, and failure of conservative treatment (activity modification, medications, and physical modalities), as criteria necessary to support the medical necessity of cervical decompression. In addition, ODG identifies anterior cervical fusion is recommended as an option in combination with anterior cervical discectomy for approved indications. Within the medical information

available for review, there is documentation of diagnoses of status post C4-C7 hybrid cervical reconstruction. However, despite documentation of subjective findings (continued pain in the cervical spine), and given documentation identifying minimal cervical symptomatology, if any; and that the intervertebral implant that was placed at the level of C4-5 has stabilized, there is no documentation of broken hardware or persistent pain. In addition, there is no documentation of a diagnostic hardware injection. Furthermore, despite documentation of subjective (continued pain in the cervical spine) and objective (limitation of cervical spine on terminal ranges of motion) findings, there is no documentation of subjective (pain, numbness, or tingling) and objective (sensory changes, motor changes, or reflex changes) radicular findings in the requested nerve root distribution. Moreover, there is no documentation of imaging (MRI, CT, myelography, or CT myelography & x-ray) findings (nerve root compression OR moderate or greater central canal stenosis, lateral recess stenosis, or neural foraminal stenosis) at the requested level. Lastly, despite documentation of conservative treatment (medications), there is no documentation of failure of additional conservative treatment (activity modification and physical modalities). Therefore, based on guidelines and a review of the evidence, the request for C4-5 removal of cervical spine hardware with inspection of the fusion mass and possible regrafting, C4-5 anterior cervical discectomy and fusion with instrumentation, iliac crest aspiration/harvesting, possible junctional levels is not medically necessary.

Medical Clearance: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disabilities guidelines

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.